failures while still adhering to the transition timeline. Clinician assessment of the FMEA process using a 5-point Likert scale found that participants felt the 'rapid-cycle' model was effective and efficient. Post-transition assessment of patient engraftment, graft failure, and safety event reports provide initial confirmation that product and patient safety were maintained during this transition.

Traditional vs. "Rapid-cycle" FMEA

	Traditional FMEA	"Rapid-cycle" FMEA
Purpose	A systems-oriented, prospective approach that identifies potential process fail-points, assesses their level of risk, and helps prioritizes response with the goal of reducing error occurrence and/or mitigating harm	
Facilitator responsibilities	Coordinate FMEA meetings - provide expertise and accountability.	Coordinate FMEA. Prepare initial process flows. Begin failpoint identification. Calculate risk priority numbers and categorize failure modes (high, moderate or low severity).
Group member (Clinician) responsibilities	Perform process mapping. Identify and score failure modes. Calculate risk priority numbers and categorize failure modes (high, moderate or low severity). Identify corrective actions.	Focus on failure mode identification, scoring and correction.
Meeting requirements	6-12	2
Timeline	4-12 months	2-4 months

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A HEMATOPOIETIC STEM CELL TRANSPLANT QUALITY, CLINICAL, CELLULAR DASHBOARD: WHAT IS THE EVIDENCE?

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Identifying HSCT clinical, quality, cellular indicators with valid benchmarks is essential to evaluate quality of care and provides direction for program management and growth (strategic planning). Indicators and benchmarks are selected based on level of evidence (clinical trial results, survey reports, international and national research data bases), best practices among centers, and institutional reports. This paper describes the process that an academic institution used to develop and mainatin an up-to-date HSCT clinical, quality, cellular dashboard. Using a reveiw of the above literature, HSCT indicators were evaluated based on the following five categories: 1) level of priority (relevance), 2) established benchmarks, 3) relationship between process and outcomes, 4) measurable with numerator and denominator, and 5) ease of data collection. To explore how variations in institutional and administrative infrastructure, patient population served, and practice and treatment patterns influences outcomes and establishment of benchmarks, a critique of the literature that examined the following indicators was conducted: microbial contamination of product, blood stream infections, time to engraftment, ICU admissions, length of stay, mortality, grade 3 – 4 toxicities. The dashboard guides the Quality & Performance Improvement Agenda. Opportunities for improvement are identified.

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CRITICAL COMPONENTS OF PATIENT SATISFACTION IN LARGE STEM CELL TRANSPLANT OUTPATIENT CLINIC

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Measuring patient satisfaction in the outpatient clinic of one of the largest stem cell transplant centers in the country is important to ongoing improvement of the program. It is also a key activity of clinical administrative staff in their quest to improve clinic functions. Nursing leaders in the Stem Cell Transplant Outpatient Clinic identified and measured three targeted patient satisfaction areas, and based on their findings, implemented changes. The focus areas included phone communication, continuity of care, and "wait times". A patient survey process and questions were developed. Survey questions included items about ease of contacting clinic staff, how long they were placed on hold, and if staff returned calls. Patients were asked if they knew their team, were informed of tests, and received consistent information. They were also surveyed about length of wait times and time from arrival to seeing their physician, perceptions of acceptable wait times and whether they were kept informed. Over 100 patients have been surveyed at 6-month intervals with return rates exceeding 80%. Based on survey findings in these areas, improvements were made including installation of a new phone system, voicemail guidelines, a team member sheet, and revision of education materials. Measurement and evaluation of patient satisfaction continues to be an important role for the SCT leaders. Utilizing the survey process, the team is able to review results and implement action plans for improvement. Staff involvement has been key to the success of this process. Discussion of results, action plans, and outcomes are done at staff meetings. Continual follow-up and evaluation are necessary to assure improvements are sustained. The findings and improvements made by the SCT leadership team may be useful to other nurse leaders and staff in their efforts to improve patient satisfaction, a key component to the success of the SCT journey.

TRANSPLANT NURSING: RESEARCH

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COLONIZATION OF TOTAL PARENTERAL NUTRITION ADMINISTRATION SETS IN IMMUNOCOMPROMISED CHILDREN

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Purpose: To determine the incidence of bacterial and yeast colonization in total parenteral nutrition (TPN) fluid administration sets in immunocompromised children and to explore the incidence of infusate-related bloodstream infection (BSI) in this group of patients.

Background: Routine replacement of IV administration sets has been advocated to prevent infectious complications of IV therapy (deMoissac, 1998). Research studies to date provide no data for infusate-related BSI that compares administration set changes at intervals of 72 hours and 96 hours among patients receiving TPN (Gillies, 2004).

Sample and Methods: The sample included 14 immunocompromised children who were receiving TPN. Five infusate fluid samples were collected from each patient for a total of 69 samples. Qualitative cultures of the TPN fluid were obtained to determine the incidence of colonization with bacteria and yeast. A 1 ml sample of TPN fluid was obtained at times 0, 24, 48, 72 and 96 hours after a new TPN administration set change. Specimens were obtained from the injection port immediately above the filter. TPN fluid bags were changed every 24 hours.

Results: Twelve bone marrow transplant patients and two oncology patients with double lumen central lines participated in the study. None of the TPN infusate fluid samples were colonized with bacteria or yeast at any of the data collection time points.